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Alternatives to Traditional Individual Disability Reinsurance

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Summary: Traditional reinsurers have become more conservative in recent years as the individual disability insurance (DI) industry continues to report poor financial results. Some reinsurers have exited the marketplace, while some others have raised rates, restricted certain coverages, tightened underwriting, and taken other actions to manage the risks.

Mr. William J. Thompson: I'm a consulting actuary with Milliman & Robertson in Hartford. With me on the panel is Inger Harrington, who is an actuary at CIGNA Reinsurance. She's been with CIGNA for 15 years. Before reinsurance she worked in individual life and disability, group pensions, and healthcare areas.

We also have Todd Spooner, an FSA and second vice president with Lincoln National Reinsurance. Todd is director of financial reinsurance, where he is responsible for developing and marketing capital management products to life, health, property and casualty (P&C) insurance, and reinsurance companies.

I'd like to spend a few minutes on the history of the individual disability market over the past decade or so. Back in the early to mid-1980s, the individual DI marketplace was experiencing rapid sales growth. At the same time, benefits were fairly liberal, underwriting was considered loose, pricing was on the optimistic

side, and reinsurers were generally supportive of the direction the direct writers were taking with the types of things they were doing.

Then came the late 1980s. Starting around 1987 or so, there were some hints that claim experience wasn't quite what people were hoping it would be. By the end of the 1980s, it was reaching epidemic proportions. Direct writers began doing things such as restricting the products they would offer, rerating products for new sales (most of the industry was writing noncancelable business so they couldn't change the rates on existing business), and implementing tough underwriting. In addition, claim practices were moved to more stringent levels than they had been before, and we started to see some movement in parts of the industry toward guaranteed renewable. Some companies moved very strongly that way, other companies are still very much committed to noncancelable. The consequence of these actions was that the new business being written was having improved profitability; however, because the large blocks of in-force business continued to have financial troubles, overall financial results were still not very good.

What was the reinsurers' response? Reinsurers' experience was generally even worse than direct writers'. They received the worst of the worst, and many reinsurers began increasing rates for new products and for new sales of existing products wherever they could. I recently learned of one company whose yearly renewable term (YRT) reinsurance rates just doubled. Historically, reinsurers writing coinsurance and some other reinsurance arrangements were locked into the rates the same as the noncancelable writers; consequently, these reinsurers had no ability to get any rate relief. In response to these problems, reinsurers have instituted tighter underwriting, restrictions on the policy provisions that they will cover, and lower automatic issue limits. Some reinsurers have exited the individual DI market so the marketplace is becoming smaller.

Direct writers have had a great deal of concern about their ability to get reinsurance coverage for the book of business they have in force, the cost of the reinsurance, and the restrictions that reinsurers are placing on their business practices. It is becoming common for reinsurers to say, "I won't reinsure this type of coverage. You need to change this provision this way. You need to underwrite this way in order for us to reinsure it." Having reinsurers getting into their business practices was becoming troublesome for the direct writers. In response to these actions, the industry is finding alternative ways of reinsuring their disability business. Inger and Todd will talk about some of these options in more detail.

Earlier we talked about the rapid sales growth of the early to mid-1980s and what's happened since then. The individual noncancelable DI sales growth of the nine largest companies was in the double digits, over 15% in 1986. Then, suddenly, as

experience started to worsen, the sales dropped off, and the industry has had negative rates of growth in recent years.

In these same nine companies, the benefit ratios of individual noncancelable DI on a statutory basis, where a benefit ratio is defined as incurred loss ratios including the change in active life reserves, are opposite of the direction of the sales curve. The result of this experience is that profitability has deteriorated.

Ms. Inger S. Harrington: Let's talk about a reinsurance pool for the individual disability income marketplace. I'll talk about the objectives of this pool, volatility, and then go through the mechanics of how the pool operates.

The unusual thing about the pool that I want to mention right off the bat is that in addition to the members of the pool ceding their DI business to the pool, they also are assuming back from the pool a portion of the overall pool experience. In essence, the members are reinsuring each other. The pool is not designed to create winners or losers. Over time, each company will be charged with its own experience plus an administration fee. This differs from traditional reinsurance where you have winners and losers. The direct writer typically pays the premium to the reinsurer, and the reinsurer pays the claims. If the claims exceed the premium, the direct writer wins and the reinsurer loses. That's not what we want to happen here. We don't want to have some members of the pool winning, and other members of the pool losing. We think we have a way to accomplish this, which I'll describe shortly, but first I'll talk about the genesis of this pool.

The concept came about in direct response to the very things that Bill has mentioned about the marketplace, things like reinsurers leaving the marketplace due to poor experience, other reinsurers raising their rates wherever they can, and reinsurers becoming more restrictive in the types of business that they're willing to reinsure. All the actions the reinsurers have taken make a lot of sense from the reinsurer's perspective. Obviously, reinsurers can't stay in business if they're losing money, so they have to do these things. But all of these things were not welcome news to the direct writers.

I don't know if many of you know Jim Grant, but Jim is an intermediary with Collins Associates, and he's been meeting with a number of direct writers and hearing the concerns that Bill mentioned. Concerns were voiced about lack of capacity in the marketplace, increasing rates, and reinsurers getting deeper into their business, telling them what they had to do, and also feeling like their hands were tied, and that they didn't have a lot of options. So Jim brought together people from Milliman & Robertson (and Bill Thompson is one of them) and CIGNA Reinsurance. He approached Milliman & Robertson because the company has a great deal of

actuarial expertise in the DI marketplace, and he approached CIGNA Reinsurance because we're running a successful reinsurance pool for individual life business. We thought we could come up with a solution that really addresses the problems of the marketplace. The result of our efforts is the pool that I will talk about.

The five main objectives that we had in mind when designing the pool are as follows:

1. Smooth, predictable earnings
2. Put a cap on losses
3. Lower costs
4. Cause minimum intrusion into daily business practices
5. Offer a full range of reinsurance services.

The first objective is the key to the pool and is the most important. It is to ensure smooth, predictable earnings for the members of the pool. It's designed so that DI managers can avoid the difficult situation of having to go to senior management towards the end of the year with bad news. Comments like "things are looking bad," and "we're not meeting our earnings objective," can be avoided with the pool. This is very important to many managers because top management seems to be less tolerant of deviations from expected earnings than in the past. The marketplace is more competitive and there is more pressure on actuaries to be able to predict what their claim experience and their earnings are going to be. If you are the pricing actuary or the managing actuary for a disability line of business and claims look great through November, you would be unhappy if two new claims hit in December and all of a sudden what looked like a great year or an "on target" year turned out to be one where you lost money. The pool was designed to avoid this situation.

Here's how the pool works: all members of the pool combine their experience in the pool. They cede policies to the pool, and then they assume back a share of the overall pool's claim experience. Each company's result after reinsurance is more predictable than before reinsurance because:

1. Experience on a big group (the pool) is more predictable than on a small group
2. Each company's share of the pool's claims is fixed ahead of time.

Bottom line, by joining the pool, members can better predict and manage their earnings. What this means, though, is that after reinsurance some companies end up with claims that are higher than what they actually experienced. This occurs when their claims were better than expected and there were other companies in the

pool with claims worse than expected. The “better than expected” companies pick up some of that “worse than expected” companies’ claims.

Now you might be thinking, “what if all of the companies had bad experience in the same year?” bad meaning worse than expected. Here’s where the second objective of the pool comes into play, capping the pool’s losses. We built into the pool an aggregate stop-loss coverage. It kicks in only after all of the experience combined in the pool exceeds the attachment point. In the first year we set the attachment point at 125% of expected claims. So any excess of pool claims over 125% of expected is picked up by the stop-loss carrier. The remainder is spread among the pool members according to their pool share. The stop-loss protection is a very good benefit for the members of the pool because they are assured that under no circumstances will they have higher claims than 125% of expected. This may be particularly attractive to small to middle-size insurance companies that, on their own, would find it very difficult to find affordable stop-loss protection.

A third objective that we had in mind in putting the pool together is to have lower cost—lower than traditional reinsurance—for the same types of services, and the same type of risk that the pool is assuming.

The fourth objective is to minimize the extent of intrusion into each company’s daily business practices. Most companies don’t like people telling them what to do. Understanding what each company is doing is critical for the success of this pool. However, it is equally important for us to leave it up to each company to determine for itself who it wants to cover, what types of benefit provisions it wants to have, and what types of features it wants to offer. We have to know this information so that we can accurately predict the claim experience for that company and the pool in total, but we’re not telling a company it can’t write a lifetime benefit if it wants to.

The fifth and final objective of the pool is to provide a full range of reinsurance services. The pool can be used in two ways. Direct writers could decide if they want to cede into the pool a portion of their risk below their normal retention, or they could decide that they want to replace their traditional reinsurance and put all of their business in excess of their retention into the pool. In the latter situation, we wouldn’t want them to feel like they were giving up some service, that they couldn’t call and ask for advice on a particular claim or a particular individual policy that they were looking to underwrite. Those services are part of this reinsurance pool.

Before going into an example of how the pool works, I’d like to briefly review volatility of risk. First, even if the actuary accurately predicts the average incidence and termination rates for the disability income block, the actual experience of the

company can deviate from expected due to normal statistical fluctuations. Second, the bigger a company is, the more predictable the results are. These two facts are key to the pooling concept. If you could do a perfect job predicting expected claims, you would have 100% probability that your claim experience would equal what is expected. If illustrated by a graph where the x axis is the percentage of expected claims, and the y axis is the percentage of time claims equal each percentage of expected, you would find a vertical line at 100% of expected. The graph for a small company in practice looks more like a horizontal line with a slight hump centered at 100% of expected. Only a very low percentage of the time will you exactly hit your expected claim target. Most of the time, you will be higher or lower than you expected.

For a medium-sized company, claim experience is more predictable. You will hit your expected claim level more of the time than if you're a small company, but even that graph would show a lot of variation around 100% of expected. A pool with 15–20 small- to medium-sized companies will experience claims close to 100% of expected much more frequently than any individual company in the pool. Its graph is much closer to the 100% vertical line. Also note, the stop-loss coverage for the pool would cut off the right tail of the graph, limiting the maximum claim level.

How does the pool do these things? There are four steps in the pool's operation:

1. Estimate expected claims per member company
2. Determine pool shares
3. Establish stop-loss attachment point for the pool
4. Allocate experience among members.

First, we have to estimate the expected claim level for each member company, which is no easy task. There are two components to this process:

1. Using the M&R Disability Table, we calculate expected claim costs. The result represents the claim level expected for the company if it is experiencing morbidity at the industry average.
2. We determine how each company differs from the industry-average morbidity, assigning a morbidity adjustment factor to each company. The expected claim number from component one above is multiplied by this factor. We determine the morbidity factor by having an underwriting expert and a claim expert visit each company. They will look at the company's claim and underwriting manuals, pull claims and underwriting files at random, talk to senior management, and get information on their sales practices and their recent claim experience. Based on

this, they will assign a preliminary factor to each pool member. The factors for all companies will be compared to make sure the relativities are reasonable and the morbidity factors will be finalized. After the first year, the morbidity factor will be experience rated using each company's actual experience in the pool and a credibility table. Over time, a company's multiplier reflects more and more of its own experience.

Let's discuss the four steps in the pool's operation starting with the first one. Let's say Company A has \$91 of expected claims under the industry table. Its morbidity multiplier is 1.1, so the actual expected claims or the annual expected claims under the pool is \$100. The same thing applies to Company B. Expected claims based on the industry-average morbidity are \$167. We think its morbidity is 20% higher than the industry average, or 1.2, so the expected claims for Company B are \$200. For Company C, the expected claims are \$316. The morbidity multiplier is 0.95 and the annual expected claims are \$300.

In the second step, we determine what each company's pool share percentage will be. This is the proportion of the total pool's claims that will be allocated to each company. The pool share for company A is 16.67%. We expect \$100 out of a total of \$600 in the pool to be attributable to Company A. Company B has \$200 out of \$600 or 33.33%, and Company C has \$300 out of \$600 or 50% of the claims. No matter what happens to the pool, Company A's share is 16.67%.

The third step sets the stop-loss attachment point. In the first example, the attachment point is found by multiplying the expected claims of \$600 by the corridor percentage of 125%, yielding an attachment point of \$750. If during the year the claims exceed \$750, the stop-loss coverage picks up the excess and only the \$750 will be spread among the pool members.

Step four takes the actual experience for the pool and assigns a portion to each pool member. Company A had exactly the claims that it expected. That's an unusual event, but possible. Company B had more claims than expected, and Company C had less claims than expected. All totaled the pool had \$620 worth of claims, which falls below the \$750 stop-loss attachment point. At the end of the year, the \$620 gets spread among their member companies, each according to their predetermined share for the year. Company A actually received a slight increase. After reinsurance, it has \$103 of claims on its books instead of \$100, Company B has \$207 instead of \$260, and Company C has \$310 instead of \$260. A company joining a pool has to be willing to accept this sort of adjustment to its results.

Note that Companies B and C are both closer to their expected claim levels after the reinsurance than before. Company B was expecting \$200; after reinsurance it has

\$207 of claims on its books. Company C was expecting \$300, after reinsurance it has \$310 of claims on its books. That's worse than \$260, but as the years go on, Company C will experience claims closer to expected. This occurs because we experience rate the morbidity factor.

Let's talk about what happens when the stop-loss attachment point is exceeded. The actual claims for the year total \$800. Everything else is the same as in our prior example. The attachment point is still \$750. The stop-loss carrier pays the excess, \$50, and only the \$750 gets allocated back to the pool members. The pool members end up with 125% of their expected claims.

I mentioned that we wanted to provide the same services to the pool members as they receive under traditional reinsurance, and this is just quickly a list of what that would be. It includes underwriting advice, claims advice, actuarial support, pool management, and financial reports.

The pool is still just a concept at this stage. In order to start the pool, it's important to have about ten companies join the pool. We need this number to ensure a good cross section of risk. We don't want two companies to dominate the pool. We want different types of businesses being in the pool, blue collar, white collar, short-term, and long-term types of benefit periods. The better the cross section, the more likely that the experience of the pool members will not move in tandem with each other. We also have a threshold in terms of the size of the pool, and in the first year, we've set the minimum size at \$15–20 million of expected claims. Anything less than that makes the stop-loss portion of the pool very expensive and it also makes it difficult for the pool to operate smoothly.

Mr. Todd P. Spooner: I would like to discuss my philosophy on reinsurance coverage and how that leads me to conclusions on alternatives to traditional disability income reinsurance. First of all, in an efficient marketplace, risks are traded over a narrow band of prices. In stock markets and bond markets, those instruments trade pretty tightly. The spreads between what a buyer will accept and what a seller will accept is pretty narrow, and the same should be true for reinsured risk. Over time, in an efficient marketplace, the pricing for risks will be narrowly bounded, but unlike other financial instruments that trade very efficiently, reinsurance involves a fair amount of additional cost.

Underwriting, administration, audit, actuarial, and all other areas all add sufficient cost to the ultimate trading price. In addition, unlike other financial instruments, I feel that ceding companies have considerably more information about their business than do reinsurers, and that tends to create what I call a bid/asked spread—spread between the acceptable price for ceding risk and the acceptable price for assuming

risk. Those three things combine to make it difficult to trade reinsurance. In fact, the conclusion I've reached is that in order for reinsurance to exist, it has to create value. It cannot survive purely as a vehicle to transfer risk.

Continuing with this line of thought, how can value be created through reinsurance? One answer is for the reinsurer to help improve the profitability of the underlying business. The reinsurer may be able to do this because it may have more knowledge or information about the management of that business or the field in which the ceding company operates. The reinsurer can lend that expertise to the ceding companies by helping them develop products and/or underwrite products. In the DI business it may be helping them manage their claims, or the reinsurer may have a better investment department and can help improve the yield on the block of business through its investment expertise.

Outside of improving the profitability on the business, creating value is limited to what I call arbitrage opportunities, and you'll find I define arbitrage very broadly. In my mind arbitrage is really the essence of creating value through reinsurance. The traditional form of arbitrage with respect to reinsurance is arbitrage of the utility function. A ceding company has a risk that, according to its utility function, is very expensive to keep. According to a reinsurance company's utility function, it's quite cheap. That's what it does, that's its business. Reinsurance companies accumulate risks and can do it much more cheaply (on a true, risk-adjusted basis) than can a ceding company. Very closely aligned with that is capacity. Lack of capacity is nothing more than an acknowledgment that the additional risk is not price attractive at the point on the risk taker's utility curve.

Another opportunity that reinsurers present is cost of capital. Often ceding companies cannot generate capital as efficiently as reinsurance companies because they're perceived differently by the markets they operate in, because they're under different regulatory constraints or for other reasons.

A third opportunity (and a big one) in the arbitrage category is the perception that external audiences have toward the business we do. I'm talking about rating agencies, analysts, banks, and so forth, and sometimes their perception becomes reality, even when the economic fundamentals belie it. There's often a sizeable gap between the implicit cost that external audiences apply to something and its real economic cost. That being the case, it can be advantageous for a ceding company to shed risk and arbitrage that perception whereby both the reinsurer and the ceding company can make money by improving the external perception.

How do you apply that sort of philosophy to individual disability income? My focus is on in-force business primarily, and that's the motivation behind many of my

comments. In-force business in general and individual disability income business in particular have a considerable information bias in favor of the ceding company. Disability insurers know much more about their business than do their reinsurers. They have a greater ability to manage the business to profitability (or lack of profitability) than other insurance companies, and that being the case, it's very hard to bridge this gap of the bid/asked spread. Consequently, traditional reinsurance is very hard to place. Few are willing to assume DI risk for a price at which the ceding company is willing to sell it.

Is there an opportunity to create value through improving the underlying profitability of the business? We talked about claims management or investment management. But these are the kind of businesses that everybody wants to get in. They're risk free, a source of fee income, and require very little capital. They're used to spread costs across the other operations, and very few companies are willing to part with those functions. Generally these do not create a good opportunity for reinsurers to create value. On the other hand, there is an opportunity to arbitrage the investment function for many disability income writers because that business has an extremely long cash flow duration. Because of negative cash flow in policy durations, sometimes portfolios of disability income will have durations anywhere from 12 to 15 years, so very aggressive, long-term investing may make good sense for that business. You can create value with that approach, but it's oftentimes not very practical in a U.S. regulatory environment. Investment limitations and capital requirements make it difficult to do this at the U.S. insurance company level. That's why reinsurance and perhaps taking it out of the U.S. regulatory environment can create an arbitrage opportunity.

Continuing with some philosophical thoughts on how to create value through arbitrage, disability income is a very capital intensive business. It involves high acquisition cost and surplus requirements, interest discounting on claim reserves, high tax cost from deferred acquisition cost (DAC) tax, and interest rate differential on claim reserves. These things add up to a great degree of capital consumption. And while much of disability income risk is off the scale relative to many other what I deem "equity" risks of insurance companies, much of the DI business has very debt-like characteristics, creating an opportunity to arbitrage the cost of equity capital versus the real economic cost of the particular risk involved.

The negative perception associated with disability income business may make it difficult in today's market for disability companies to raise capital. Recent past experience could lead one to say that the disability income business has been a bad business to be in, but some people would say that it's never been a better time to be in the disability income business. Prices are fantastic right now. Policy provisions in new contracts are very reasonable, and this is a great time to take advantage of

the opportunity presented by the disability income marketplace. That requires capital. If companies can't raise that through traditional methods, reinsurers may be able to help them out. That may carry over to other parts of the company too. DI is a sideline business to some companies, but negatively impacts their core businesses such that they can't produce the business they otherwise would. If they could dispose of this "ugly" liability, the disability income business, through reinsurance, it could free up opportunities for the rest of the company. That's another arbitrage opportunity.

Let me give you some specific examples. The first example, the banana principle, goes like this. We need to differentiate between the labels attached to things and their underlying economics. If the underlying economics are sound but the label associated with it make it such that people perceive it poorly, simply call it a banana. Convince others that the economics make sense, and put a different label on it. Broad groupings of things under a single label may create an impression for the components' parts, which is unfair. When the components' parts are not consistent with the whole, the better parts will suffer. The banana principle, in reality, is the central theme in arbitrage.

The continuous versus discrete basically says that human beings are unable to evaluate things on a continuum. We have to break things down into parts; the human mind can only handle so many discrete parts. That's true also of external audiences; for example, rating agencies break things down into parts. Consider our risk-based capital (RBC) formulas. Everything is broken down into parts to which factors are applied. It's just not precise enough to reflect the true continuum of risk that exists; therefore, there is another opportunity for arbitrage. Look at risk as continuous rather than discrete points, and I'll describe what happens when you apply that to disability income. For "normal" life insurance business, the required return associated with its continuum of risk increases slowly but steadily as you go further out on the risk spectrum.

Disability income gets very risky as you move outward on the risk spectrum. It's much more risky than other insured risks and that, by its nature, creates greater arbitrage opportunities.

Now consider two claim reserves of \$100,000. One is a 27-year-old, 90 days from disability. The other is a 42-year-old, 5 years from disability. Let's assume a 7% interest rate in calculating my gross premium valuation amounts. If one assumes that termination rates can deviate by 50% from the table rate, you can lose almost \$200,000, almost twice the amount of reserve on the 27-year-old claim. You can lose about \$3,000, or 3% of the claim reserve on the 42-year-old claim. What's the upside? Well, the upside on the 27-year-old claim is to profit about \$68,000. For

the 42-year-old claim you can profit about \$30,000, which is not as much, but it's much more stable. Let's consider the ratio of the upside potential versus the downside potential. For the 27-year-old the ratio is 35%. That's not a risk that I would be willing to take for anything but an exorbitant price. For the 42-year old, the corresponding ratio is almost 10:1. Now that sounds like a very good risk, where the economics are pretty good, and one ought to be able to price that fairly inexpensively. In spite of these facts I think that most external audiences would view these two claim reserves as equivalent.

Now let's talk about capital cost arbitrage and the issue of tax costs. Assume a block of claim reserves has an average statutory discount rate of 5%, an average federal income tax (FIT) discount rate of 7.5%, and an overall claim duration of 6 years. Using the traditional "change in I times D " formula, that produces tax reserves of 85% of statutory reserves. That's a pretty high differential and typical of many claim reserve blocks I've seen. Assuming the company acquires capital, an after tax cost of 11% (you can debate whether or not that's a reasonable figure or not), let's consider what the tax cost really is.

Accelerated taxes are really a loan from the U.S. government, and as such ought to have a low financing cost associated with them. Assuming good credit, the only risk is that you cannot recover those taxes in the future—not that much risk in reality. A ten-year Treasury has about the same duration as the claim reserves I've assumed. If you assume that nonrecovery risk deserves a 1% annual spread, the "true" financing cost of taxes is really 7.75%. Now what I call the arbitrable yield spread, the difference between the equity cost of capital and the "true" financing cost, comes out to almost a 0.5% point per year per dollar of claim reserves. Now I think many investment departments would get very excited if you could show them how they can make an extra 0.5% point per year on a large block of reserves, essentially risk free.

Mr. Timothy L. Giles: What is your opinion of the 1985 Commissioners Individual Disability Table A (CIDA) as a predictor of the expected claim cost? You said that Milliman & Robertson had its own table.

Mr. Thompson: Every study that we've done shows that CIDA is deficient in most respects. The incidence rates generally tend to be running a little bit better than the table. However, terminations are quite a bit worse than the table. Therefore, the table is somewhat light on a claim-cost basis, and it's probably quite a bit light for claim reserves, especially in the early durations of disability. The table is also misaligned with respect to slope by duration of disability, by elimination period, and by age. As a result of the misalignments, the amount of margin or deficiency

varies a great deal from cell to cell. It's probably time for some major revisions to the industry standard table.

Mr. Albert A. Riggieri, Jr.: I'd like to have both speakers comment on risk transfer. I think it will be an important element of any reinsurance that goes on in the future in the DI line, and both concepts seem to limit the amount of risk transfer. I'd like to hear more about that.

Ms. Harrington: Well, it is true on the reinsurance pool. The only risk transfer away from pool members is at the stop-loss level. This is because of the recent poor experience. I know that's the reason we looked for a way of helping the marketplace out without having to take the full risk ourselves. It's something we don't feel we can do at this time.

Mr. Spooner: I guess I'd separate your question into two parts. With respect to appropriate accounting and compliance with regulations, I don't think either of us is contemplating anything that is a problem. The second part of my comment addresses reinsurers taking a great deal of risk. Quite frankly, I don't think that the market is ready to pay that price. I think that most reinsurers feel that the problems the industry has gotten into are theirs to keep, and that the risk that they'd be willing to reinsure has a certain price associated with it, and it's fairly high.

Mr. Thompson: Historically, a number of companies have used reinsurance as a way to lay off their mistakes in terms of risks that they really didn't want to take at all. In the past, reinsurers have taken those risks. As we're seeing now, they are less receptive to such risk taking. Instead there are arrangements under which a company can spread some of the volatility in its results.